

# SOUTH CAROLINA INSURANCE FRAUD COMPLAINT FORM

Date: \_\_\_\_\_

Your Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_

(work) \_\_\_\_\_

(fax) \_\_\_\_\_

**What is the false statement/misrepresentation/crime you believe was committed and by whom?** (Include details such as names, addresses, and telephone numbers of witnesses to the events you describe. Use additional sheets, if necessary. Attach copies of any supporting documentation to this complaint.)

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**How do you know it is a false statement/misrepresentation/crime and what facts support your conclusion?**

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**Why does the false statement/misrepresentation matter?**

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**Did a licensed professional participate?**

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<b>Amount Involved:</b> (claimed) \$ _____	<b>Date of Loss:</b> _____/_____/_____
(paid) \$ _____	<b>Date of Claim:</b> _____/_____/_____

**Individuals Involved:** (If available, include names, addresses, and telephone numbers of any parties involved.)

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**Other Agencies or Individuals Contacted About This Matter:** \_\_\_\_\_

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**Mail completed form, and all relevant documentation to support your complaint, to:**

Insurance Fraud Division  
Office of the Attorney General  
P. O. Box 11549  
Columbia, SC 29211-1549

Telephone: (803) 737-6424  
Fax: (803) 253-4121